CORRESPONDENCE

We may shorten letters to the editor unless the authors specifically state that we may not. This is so that we can offer our readers as wide a selection of letters as possible. We receive so many letters each week that we have to omit some of them. Letters must be typed with double spacing between lines and must be signed personally by all their authors, who should include their degrees. Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included.

The Warnock report

SIR,—Dr M M Heley (18 August, p 440) affirms: "Life begins at conception. Can anyone prove otherwise?" Many others are of the same opinion, but of course this is not so—whether one equates conception with fertilisation or with implantation. Life on this planet began many hundred million years ago in circumstances about which we can only speculate and has continued uninterruptedly ever since. No one now seriously supposes that the living has subsequently ever arisen from the inanimate. Equally it is obvious that the gametes, sperms, and eggs are living cells themselves the products of living cells. How much respect is due to the life they represent is a matter for argument—as is that due to other expendable cells, such as leucocytes and the cells lining the gut or covering the skin.

Even under the most favourable biological circumstances each of the few million oocytes in the ovaries of a human fetus has a chance of no more than about one in 200 000 of becoming a child; and in actuality the chance is more like 1 in 2m. The fate of the remainder is to disappear by atresia or through loss after ovulation without fertilisation. The corresponding chances for an individual sperm are several orders of magnitude less. Just what "rights" might, nevertheless, be accorded to these living human cells are difficult to conceptualise.

Dr Heley might well argue that the gametes are incomplete organisms, lacking half the chromosomes, incapable of independent existence, and, therefore, even though living, in a different category from zygotes, which have the potential for development into complete individuals. Though this may be true for implanted embryos, it is not—or at any rate not yet—true for unimplanted embryos. It might therefore be argued that the rights of the latter are intrinsically less than those of the former. Yet a further difficulty may arise in according "rights" to the fertilised but unimplanted egg. Some of these are incapable of forming a germinal disc and hence a fetus but will instead finish up as an empty sac; few if any "rights" could be accorded such a structure or indeed the corresponding pregerminal disc zygote.

It seems unwise to be too dogmatic about considerations of this kind. The pragmatic attitude adopted by the Warnock Committee is temperate and altogether more acceptable.

G I M SWYER

London NW3 6AU

SIR,—Professor G R Dunstan believes that embryos do not have full human rights, that absolute protection for the embryo is a novelty of moral tradition, and that experimentation on human embryos is justified by benefiting the community as a whole (28 July, p 207).

The Royal College of General Practitioners believes: "The onset of human life . . . can be considered to commence at fertilisation . . . the point at which a genetically complete embryo is formed. From that moment the embryo should be treated with respect and experimentation on human embryos should be subject to the same ethical considerations as on children and adults." Such experimentation "is unethical because: (i) it is not in the interests of the subject under study, (ii) . . . informed consent cannot be obtained . . . (v) failure to maintain ethical standards in relation to human embryos represents a threat to the application of ethical standards in medicine and science generally."[1]

Historically denial of human moral status to a group of human beings by another group has been justified in terms of biological differences such as colour, race, sex, disability, or age.

In the Roman Empire abortion was widely accepted and was confronted head on by the expanding Christian church—so successfully that the sanctity of unborn life attained what Professor John T Noonan has called "an almost absolute value" in European history.[2] It is true that Thomas Aquinas in the Middle Ages following Aristotle maintained that the fetus attains humanity only at a certain stage of development, but the time of "animation" was never regarded as a moral dividing line between permissible and inpermissible abortion, though affecting penal practices. Even without the certainty we now have that it is human at conception the embryo always enjoyed protection of life from its early beginnings.[3] At the Reformation Calvin reaffirmed the stance of the early church regarding the scriptural doctrine of the sanctity of human life from its beginning. Only recently has there been any wavering on this issue by the professing church.[2]

The recognition that every human being has the right not to be used as a mere means to the benefit of others and every harmless human being has the right not to be killed is a "first principle" of traditional moral philo-

sophies. The Declaration of Geneva (1948) updating the Hippocratic Oath (*c* 400 BC) says: "I will maintain the utmost respect for human life from the time of conception." We need to return to this standard.

STEPHEN BROWNE

Stirchley,
Birmingham B30 2NP

1 Royal College of General Practitioners' Working Party. Evidence to the government inquiry into human fertilisation and embryology. *J Roy Coll Gen Pract* 1983;**33**:390-1.
2 Barnes P. *Open your mouth for the dumb—abortion and the Christian.* London: Banner of Truth Trust, 1984:24.
3 Inglesias T. Social and ethical aspects of IVF. In: Donald A, Scott J, White D, *et al*, eds. *Test tube babies—a Christian view.* London: Order of Christian Unity, 1984:67-89.

SIR,—I respect the views on the human embryo held by Dr M M Heley of Life (18 August, p 440). She is against the "veterinary" nature of in vitro fertilisation. But her arguments are not helped by some of her questions. She holds that human rights start at conception: "Have we forgotten our embryology, which told us without a doubt that life begins at conception? Can anyone prove otherwise?" Was there no life before? Can Dr Heley prove that the diploid state automatically confers human nature, which she means by "life?"

Dr Heley asks: "Has every couple an absolute right to a child?" She refers to the infertile, but why not the fertile too? And if so, what qualifications would she impose? She continues: "In this consumer age is a child becoming more a status symbol than a product of love?" Why "consumer?" How can children who are adopted, and acknowledged to be so, be thought of as status symbols? And if not why any other children? The baby born after much effort to a previously infertile couple, and particularly the test tube baby, is born out of enduring love, to be loved. What better?

Dr Heley wants doctors to campaign against the Warnock committee's recommendations. I hope that most doctors will campaign to help the childless through every means endorsed by Warnock. The fertile are assisted in every way (through contraception, sterilisation, abortion) as much out of expediency as compassion. The infertile deserve no less effort. There are lay organisations working for the childless. Perhaps it is time for concerted medical action. I would be glad to hear from—or join—interested doctors.

MICHAEL G R HULL

University Department of
Obstetrics and Gynaecology,
Bristol Maternity Hospital,
Bristol BS2 8EG

When breasts are bad for business

SIR,—It is a pity that Professor John Dobbing did not get his facts straight in his review (11 August, p 376) of the BBC TV programme, *When Breasts are Bad for Business.*

Firstly, the international code of marketing of breast milk substitutes was not "designed" by the "activists." I know because I, too, was there. The code was first suggested at an international meeting convened by the World Health Organisation and UNICEF in October 1979. There then followed an intense series of consultations during 1980 which involved governments, international agencies, scientific, medical and marketing experts, the infant food industry, and non-governmental organisations in the drafting of the code. After four painstaking drafts it was then approved by World Health Organisation's executive board and ratified by 118 governments at the World Health Assembly in May 1981. If the "activists" had actually designed the code it would indicate a degree of professionalism and expertise well above the "polemic" and "emotive propaganda" with which Professor Dobbing characterises activists.

Secondly, the code has not been accepted by the industry. One company earlier this year agreed to apply most of the code's provisions in most countries. Another five or six companies are now selecting which provisions they will follow in which countries. That leaves some 80 companies who have yet to give even an indication about abiding by the code.

Thirdly, the code does *not* instruct companies to promote their products only through hospitals but states: "No facility of a health care system should be used for the purpose of promoting infant formula or other products within the scope of this code."

Fourthly, there has never been any question during the decade long campaign of "abolishing processed baby food," as Professor Dobbing claims. That is a simplistic and incorrect conclusion. The many different pressure groups have been working to ensure that those products are put in their proper place—used only when necessary, not as the routine method of feeding.

Fifthly, the point about paediatricians (or other health workers) is not that they dispute the benefits of breast feeding. What the programme, and many of the health professionals appearing in it, strove to put across was that despite knowing that breast feeding offers the best start in life paediatricians and other health professionals often lack the time, the experience, and the practical knowledge to be able to provide the support, encouragement, and advice to mothers and fathers that will help deal with minor problems that arise.

Professor Dobbing claims that "research supported by the industry" has done more for breast feeding than the critics of the industry. Has it? In 1974 the research (not necessarily supported by the industry) existed to show that putting the baby to the breast immediately after birth and allowing mothers to demand feed with easy access to the baby through the practice of "rooming in" were likely to ensure prolonged and successful breast feeding. Research also showed that the introduction of bottle feeds of glucose, water, or top up milk feeds undermined confidence in breast feeding. Yet, in 1984 there are hospitals and maternity clinics in all parts of the world (staffed, incidentally, by health workers who are convinced of the benefits of breast feeding) where babies are separated from their mothers at birth, given bottle feeds before breast feeding, and where mothers may not have their infants for feeding up to a day after birth.

Furthermore, the question has to be asked whether the research has led to improvements in the social support systems—maternity legislation, day nurseries, crêches, counsellors—or has improved the status and access to education of women, thus allowing them better access to the nutritious food that they require to be able to provide for their infants. In many countries of the world far more has been achieved by those "noisy" critics, who, rather than being self indulgent, are working long hours with health workers, decision makers, educators, and the general public to distribute the information and encourage the changes required to make maternal and child health a reality, not a dream. Significantly, perhaps, in the United Kingdom it was the Baby Milk Action Coalition—not the industry, the medical profession, or even the Department of Health and Social Security—that earlier this year distributed copies of the international code to the members of the British Paediatric Association.

Professor Dobbing's main complaint is that the programme "could have been made 10 years ago. (Similar programmes were.) My main complaint is that it could equally be made in another 10 years, unless all those concerned with or influencing maternal and child health—parents, educators, health professionals, governments, voluntary agencies, the media, and the food industry—intensify their efforts. There is, unfortunately, a great deal "left to moan about," as Professor Dobbing puts it. But more importantly there is a great deal more to do, and that requires activists inside and outside the health professions.

A CHETLEY
General administrator

International Baby Food Action
Network,
London N7 9BE

Vocational training for general practitioners

SIR,—Michael Varnam asks 44 good questions about where vocational training for general practice has come from, why it is here, and where it is going (4 August, p 291; 11 August, p 358). He points up the tension between setting minimum standards and defining case law on the one hand, and spotting the more intangible qualities, such as fire in the belly, which are good predictors of future performance and service to patients, on the other. But I am not convinced that courses should be run by career diplomats. There is no real place for a course organisers' association, any more than there is for a regional or assistant advisers' one. Neither group should be divorced from the pool of doctors who have been or might be involved in that work and are able to do it but cannot do it just now.

Labels such as trainer and trainee, adviser or organiser, and doctor and principal all take attention away from the fact that we are providing a better service to help patients sort out their own problems than ever before. We all rely on the qualities of leadership in other professional groups to be defined and for standards of service to be raised in the other problem solving services at the same time, if our own efforts are not to be watered down or wasted when it comes to the moment of truth: face to face contact with the person in need.

The General Medical Council's new brief (of raising standards rather than setting minimum ones alone) needs to be seen by the patient as applying directly to him or her. Key patients in every household need to know how to use our service and how to look after their families and sort out their problems for referral or not. Forget the labels. I think that medicine is ahead of the field and is already seen as such by the public.

M J JAMESON

St Albans AL1 3UD

Familial hypercholesterolaemia

SIR,—Dr J I Mann (18 August, p 396) expresses surprise that familial hypercholesterolaemia has not aroused greater interest in view of its high frequency, ominous prognosis, and ease of diagnosis. Even more surprising, in my view, is that it has not been regarded as a model for idiopathic hypercholesterolaemia or the disease suffered by all those subjects in the Lipid Research Clinics' cholestyramine trial who did not have familial hypercholesterolaemia.[1]

Dr Mann reminds us that familial hypercholesterolaemia is the genetic deficiency of